YOUTH FUNDING DISCHARGE FORM

Today's Date: _____ EHR # _____

Client Information

1. First Name: _____ 2. MI _____ 3. Last Name _____

4. Social Security Number _____ / _____ / _____

5. Admitting Hospital:
☐ Dominion ☐ Poplar Springs ☐ Snowden

6. Authorizing CSB:
☐ Alexandria ☐ Arlington ☐ Fairfax ☐ Loudoun ☐ Prince William

This is to certify that inpatient psychiatric services have been rendered to the individual listed above by the hospital program identified above.

7. Dates of Approved Service: From _____ / _____ / _____ To _____ / _____ / _____

8. Clinical Status at Discharge / Transfer: _____

_____

9. Ongoing Follow Up / Treatment Arrangements / Transfer Location: _____

_____

10. Discharge Approval

CSB Representative Name: _____ Date: _____ / _____ / _____

Last Updated: 12/1/12

Fax to NVRPO, attention Julie Parkhurst @ 703-968-4020